St Paul Apostle North Primary School

Medication Authority Form

CHILD'S DETAILS

Child's Name: _____ **Grade:** _____

Name of Medication: _____

Reason for Medication: _____

Type of Medication: *(please tick)*

❑Tablet/Capsule ❑Elixir ❑Drops ❑Cream ❑Other: _____

Dosage ***(****Amount to be given)*: _____ **Time of previous dose** (*i.e. at home)*: _____

Frequency *(Time to be given)*:

❑Morning Recess (11.00am)

❑Lunchtime (1.30pm)

❑Other: _____

Duration:

❑This medication is for today only: Date _____

❑This medication is ongoing from _____ to _____

PARENT/GUARDIAN'S DETAILS

Parent/Guardian's Name: _____

I hereby authorise the staff of St Paul Apostle North Primary School to administer medication to my child as detailed above.

I understand that

☑students are not permitted to keep tablets or medications in their bags

☑the medication will only be given if it is in it's original container

☑prescription medication is specifically prescribed for the child named on this form

☑medications must be handed into the office/classroom teacher in the morning, and collected at the end of the day by a parent/guardian

Signature: _____ Date: _____

STAFF TO COMPLETE

Date: _____ **Dose Given:** _____ **Time:** _____

Staff Name (*print)* **:** _____ **Staff Signature:** _____

Witness *(print)***:** _____ **Signature:** _____

Please complete the back of this form for ongoing medications